State of Rhode Island Payroll Account # _____

CORNERSTONE
ADMINISTRATIVE SERVICES, LLC

flexplan©

ENROLLMENT & CHANGE FORM

DEBIT CARD PROVIDED

EMPLOYER

State of Rhode Island **July 01, 2009 - June 30, 2010**

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	HOME PHONE	
DATE OF HIRE	☐ SINGLE ☐ MARRIED	PAYROLL MODE ☐ WEEKLY ☐ SEMI-MONTHLY	
E-MAIL ADDRESS	☐ OFFICE ☐ HOME	☐ BI-WEEKLY ☐ MONTHLY	
PREFERRED COMMUNICATION ☐ E-MAIL ☐ MAIL			

VISA MasterCard

ADDITIONAL DEBIT CARD REQUEST

NAME _____ D.O.B. _____ SS# _____

THERE IS NO FEE FOR THE FIRST ADDITIONAL CARD. LOST/STOLEN CARD FEE IS $10.00 AND WILL BE DEDUCTED FROM YOUR ACCOUNT BALANCE AS WELL AS ANY OTHER ADDITIONAL CARDS REQUEST (AFTER THE FIRST ADDITIONAL CARD IS ISSUED FREE OF CHARGE).

HEALTH CARE SPENDING ACCOUNT

☐ YES, I CHOOSE TO PARTICIPATE IN THE FLEXPLAN HEALTH CARE SPENDING ACCOUNT. I AUTHORIZE MY EMPLOYER TO DEDUCT THE FOLLOWING AMOUNT. $ _____ PER PAY PERIOD FOR AN ANNUAL AMOUNT OF $ _____ NOT TO EXCEED $ 5,000.00 PER YEAR AS THE MAXIMUM ELECTION AMOUNT.

IF ENROLLING DURING THE PLAN YEAR, BE SURE TO CALCULATE YOUR ANNUAL ELECTION BASED ON THE REMAINING PAY PERIODS IN THE PLAN YEAR.

☐ NO, I DO NOT CHOOSE TO PARTICIPATE IN THE FLEXPLAN HEALTH CARE SPENDING ACCOUNT.

DEPENDENT CARE SPENDING ACCOUNT

☐ YES, I CHOOSE TO PARTICIPATE IN THE FLEXPLAN DEPENDENT CARE SPENDING ACCOUNT. I AUTHORIZE MY EMPLOYER TO DEDUCT THE FOLLOWING AMOUNT. $ _____ PER PAY PERIOD FOR AN ANNUAL AMOUNT OF $ _____ NOT TO EXCEED $ 5,000.00 PER YEAR AS THE MAXIMUM ELECTION AMOUNT.

IF ENROLLING DURING THE PLAN YEAR, BE SURE TO CALCULATE YOUR ANNUAL ELECTION BASED ON THE REMAINING PAY PERIODS IN THE PLAN YEAR.

AUTHORIZATION TO PARTICIPATE

I UNDERSTAND THAT I CANNOT PARTICIPATE IN THE HEALTHCARE FSA IF I AM CONTRIBUTING TO A HEALTH SAVINGS ACCOUNT (HSA) DURING THE FSA PLAN YEAR.

I UNDERSTAND THAT I MAY NOT INCREASE OR DECREASE THE AMOUNT OF MY INCOME REDUCTION UNTIL THE NEXT PLAN YEAR, EXCEPT TO REFLECT A CHANGE IN MY FAMILY STATUS (E.G. MARRIAGE, BIRTH OF A CHILD, DIVORCE OR DEATH). IN MAKING CONTRIBUTIONS TO THE SPENDING ACCOUNTS, I UNDERSTAND THAT I WILL FORFEIT ANY AMOUNTS IN MY ACCOUNT IF I DO NOT INCUR ELIGIBLE EXPENSES FOR THEM BY THE END OF THE PLAN YEAR. IN ADDITION, I UNDERSTAND THAT MY SOCIAL SECURITY BENEFITS MAY BE SLIGHTLY REDUCED BECAUSE I WILL PAY LESS SOCIAL SECURITY TAXES. THIS ELECTION REPLACES ANY PREVIOUS ELECTIONS AND WILL TERMINATE ON THE EARLIER OF (1) THE END OF THE PLAN YEAR; (2) WHEN I AM NO LONGER BEING COMPENSATED IN AN EQUAL AMOUNT AT LEAST EQUAL TO MY TOTAL SALARY REDUCTION; (3) TERMINATION OF THE PLAN. MY EMPLOYER MAY REDUCE OR CANCEL THIS ELECTION IF NECESSARY TO COMPLY WITH PROVISIONS OF THE INTERNAL REVENUE CODE.

SIGNATURE _____ DATE _____

EMPLOYER VERIFICATION

TO BE COMPLETED BY HUMAN RESOURCES ONLY

EFFECTIVE PAYROLL DATE _____ VERIFIED BY _____ DATE _____

CHANGE OF STATUS _____ QUALIFYING EVENT _____